

11476

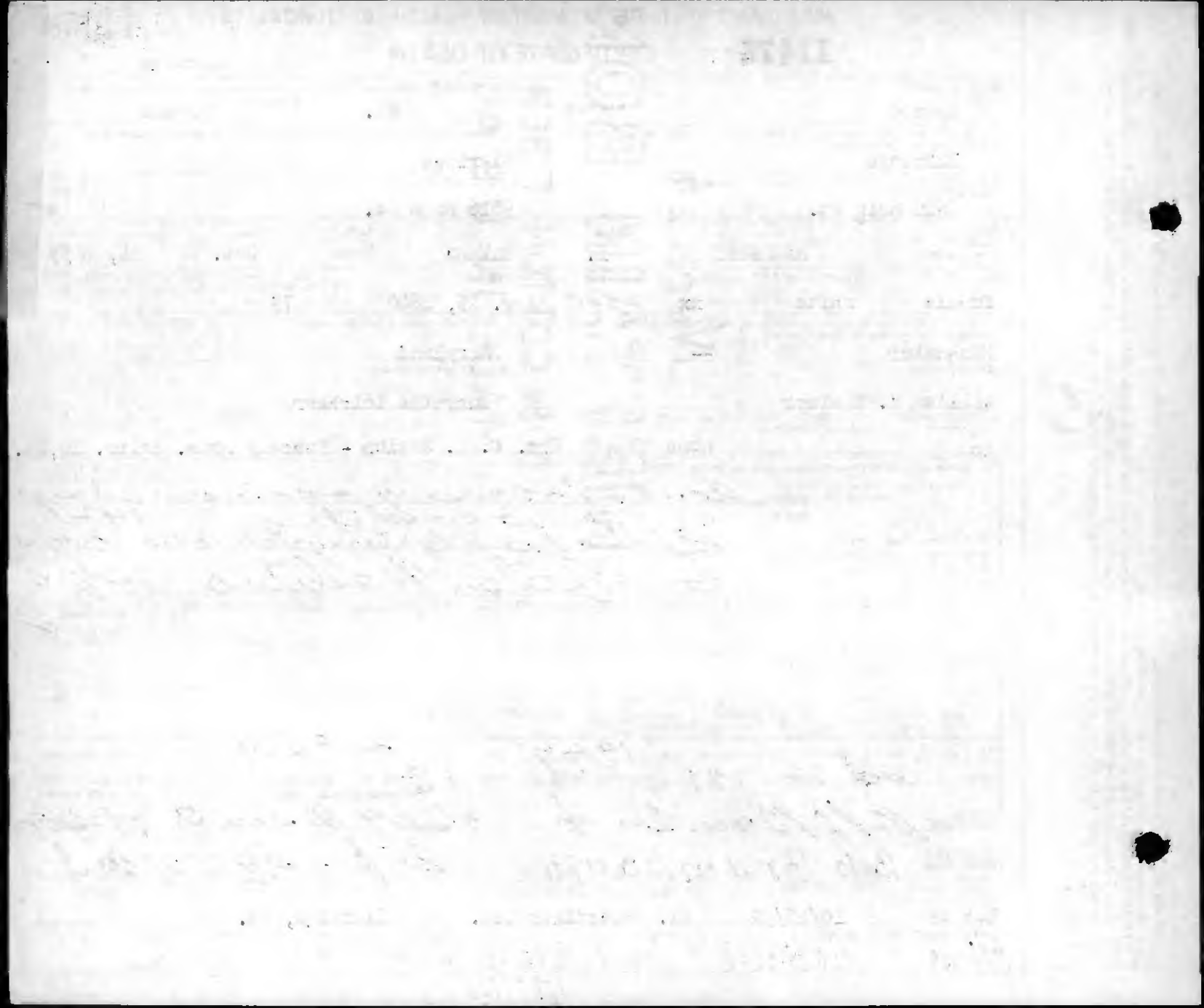
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkridge		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5616 Main St.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkridge	
f. STREET ADDRESS 5616 Main St.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARGARET Middle I. Last BAUMAN		4. DATE OF DEATH Month Oct. Day 24 , Year 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 15, 1880
9. AGE (In years lost birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William H. Trainor		14. MOTHER'S MAIDEN NAME Lucretia Leishear	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
INFORMANT Mrs. C. L. Haslup - Tuncany Apts. Balto. 10, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute coronary occlusion 260X DUE TO chronic myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) general arteriosclerosis DUE TO diabetes mellitus (c) 20 yrs INTERVAL BETWEEN ONSET AND DEATH 2 days 1 yr 10 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1945 , 19 to Oct 22 19 59 , that I last saw the deceased alive on Oct 22 , 19 59 , and that death occurred at 8:25 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1609 Main St 10/24/59 DATE SIGNED ACTUAL SIGNATURE B B Brumbaugh M.D. PHYSICIAN'S NAME (Type) B B Brumbaugh Elkridge 27 Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/27/59	
22c. NAME OF CEMETERY OR CREMATORY St. Augustine's Cem.		22d. LOCATION (City, town, or county) (State) Elkridge, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Lockner & Sons - Balto		24a. REC'D BY REGISTRAR DATE OCT 27 '59	
ADDRESS 17 Md		24b. REGISTRAR'S SIGNATURE Arthur L. K...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be required by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11477

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jessup</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jessup</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Annapolis Junction Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Josephine Edith Cooper</u>		4. DATE OF DEATH Month Day Year <u>October 28 1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 14 1912</u>
9. AGE (In years last birthday) <u>46</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>machine operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>distillery</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Band</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Reat</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-05-2565</u>	
17. INFORMANT <u>John Cooper - Jessup</u> Address <u>Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u> 171X DUE TO <u>Carcinoma of Cervix Uteri</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) <u>1 yrs.</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 26 1959</u> to <u>Oct. 28 1959</u> , that I last saw the deceased alive on <u>Oct. 27 1959</u> , and that death occurred at <u>330A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank E. Shipley</u> M.D.		ADDRESS (Street, city or town, state) <u>Savage, Md.</u> DATE SIGNED <u>10/28/59</u>	
PHYSICIAN'S NAME (Type) <u>Frank E. Shipley</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 30, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Balt. National Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>DeWitt Donaldson Kessel</u> ADDRESS <u>Md</u>		24a. REC'D BY REGISTRAR <u>NOV 2 '59</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>C. L. Evans</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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RECEIVED
JAN 10 1917
MAYOR COUNCIL
RECORDS

Name of Deceased	
Age	
Sex	
Race	
Date of Birth	
Date of Death	
Place of Death	
Cause of Death	
Occupation	
Residence	
Signature of Physician	
Signature of Registrar	
Signature of Coroner	
Signature of Minister	
Signature of Justice	
Signature of Notary	
Signature of Witness	
Signature of Deceased	
Signature of Family	
Signature of Friends	
Signature of Community	
Signature of State	
Signature of Nation	
Signature of World	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11460

Reg. Dist. No.

11/75

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural - W. Friendship		c. LENGTH OF STAY IN 1b passing through		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) × rural - Ellicott City			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Jct. of Burnt Woods Road & Rt. 32				d. STREET ADDRESS Upside - Homewood Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ann Middle Eastman Last Davis				4. DATE OF DEATH Month October Day 19 Year 19 59			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 11, '59	
9. AGE (In years last birthday) yr. 8		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) infant	
10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Olney, Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Clarence C. Davis				14. MOTHER'S MAIDEN NAME Helen Sullivan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Md. Clarence C. Davis, Upside, Ellicott City			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured skull & extensive brain damage INTERVAL BETWEEN ONSET AND DEATH instant 822X DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO _____ (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Child bumped head in car which turned over			
20c. TIME OF INJURY Month, Day, Year Hour 9:00 o. m. xx 10-19-1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) State Road		20f. (City or town) (County) Howard (State) Md. Nr. W. Friendship	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Charles S. Whitaker, M.D.</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Charles S. Whitaker, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 10-19-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-21-59		22c. NAME OF CEMETERY OR CREMATORY Forest Park		22d. LOCATION (City, town, or county) (State) Houston, Texas	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md				ADDRESS		24a. REC'D BY REGISTRAR OCT 22 '59	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krous</i>				DATE			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

2073386XV8

STATE OF NEW YORK
DEPARTMENT OF HEALTH
LABORATORY EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
Date of Death		Place of Death		Cause of Death	
Manner of Death		Signature of Examiner		Signature of Physician	
Date of Report		Signature of Coroner		Signature of Medical Officer	
Signature of Registrar		Signature of Health Officer		Signature of District Attorney	
Signature of County Clerk		Signature of County Judge		Signature of County Sheriff	
Signature of County Treasurer		Signature of County Surrogate		Signature of County Comptroller	
Signature of County Assessor		Signature of County Engineer		Signature of County Surveyor	
Signature of County Clerk		Signature of County Judge		Signature of County Sheriff	
Signature of County Treasurer		Signature of County Surrogate		Signature of County Comptroller	
Signature of County Assessor		Signature of County Engineer		Signature of County Surveyor	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 FilmG251 11-2-59 et

11479

CERTIFICATE OF DEATH

Reg. Dist. No.

195

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Georgia</u> b. COUNTY <u>Cobb</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Junction</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Acworth</u> 49X-3	
c. LENGTH OF STAY IN 1b <u>3 mos.</u>		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>"Private residence"</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lula</u> Middle <u>Victoria</u> Last <u>Dewberry</u>		4. DATE OF DEATH Month <u>October</u> Day <u>8</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 1872</u>
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR: Months <u>87</u> Days <u>8</u> Hours <u>19</u> Min. <u>59</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Cann</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>J. B. Dewberry</u> Address <u>Annapolis Junction</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.1 DUE TO <u>Hypertensive Cardis-Vas. Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>?</u> DUE TO (c) <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 4, 1959</u> to <u>Oct. 8, 1959</u> , that I last saw the deceased alive on <u>Oct. 8, 1959</u> , and that death occurred at <u>4:30 P.</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank E. Shipley</u> M.D.		ADDRESS (Street, city or town, state) <u>Acworth, Georgia</u> DATE SIGNED <u>10/9/59</u>	
PHYSICIAN'S NAME (Type) <u>Frank E. Shipley</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 11, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Acworth Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Acworth, Georgia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>De Witt Donaldson Laurel Md</u> ADDRESS		24a. REC'D BY REGISTRAR <u>OCT 13 '59</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hirsch</u>	

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

11112

1. Name of deceased: _____

2. Sex: _____

3. Age: _____

4. Date of birth: _____

5. Place of birth: _____

6. Date of death: _____

7. Time of death: _____

8. Cause of death: _____

9. Place of death: _____

10. Signature of attending physician: _____

11. Signature of registrar: _____

12. Signature of informant: _____

13. Name of informant: _____

14. Address of informant: _____

15. Date of filing: _____

16. File number: _____

17. Registrar's office: _____

18. County: _____

19. State: _____

20. City: _____

21. Zip: _____

22. Telephone: _____

23. Fax: _____

24. E-mail: _____

25. Internet: _____

26. Other: _____

27. Remarks: _____

28. Signature of medical examiner: _____

29. Signature of coroner: _____

30. Signature of judge: _____

31. Signature of jury: _____

32. Signature of witness: _____

33. Signature of other: _____

34. Signature of other: _____

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11480

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HOWARD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL, ELLICOTT CITY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ARBUTUS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Schaeffer's Convalescent Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last JOSEPHINE F. FRANK		4. DATE OF DEATH Month Day Year OCTOBER 21 1959	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 12, 1925
9. AGE (In years lost birthday) 34 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME EUSTIS NEWELL		14. MOTHER'S MAIDEN NAME MARY MOLLEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Address HENRY M. FRANK 1235 MAPLE AVE.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, breast, metastatic 170X DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH 1 yr.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct 20 , 19 59 to Oct 21 , 19 59 that I last saw the deceased alive on Oct 20 , 19 59 , and that death occurred at 4:30 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 460 Church Rd. Ellwood City, Pa. DATE SIGNED 10-22-59 ACTUAL SIGNATURE Thomas F. Herbert, M.D. PHYSICIAN'S NAME (Type) Dr. Thomas F. Herbert			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 10/24/59	22c. NAME OF CEMETERY OR CREMATORY LODON PARK	22d. LOCATION (City, town, or county) (State) BALTIMORE MD.
23. FUNERAL DIRECTOR'S SIGNATURE GEORGE L. SCHWAB (BARBARA SCHWAB SUCCESSION)		24a. REC'D BY REGISTRAR OCT 26 '59	24b. REGISTRAR'S SIGNATURE Charles S. Hume

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11250

1

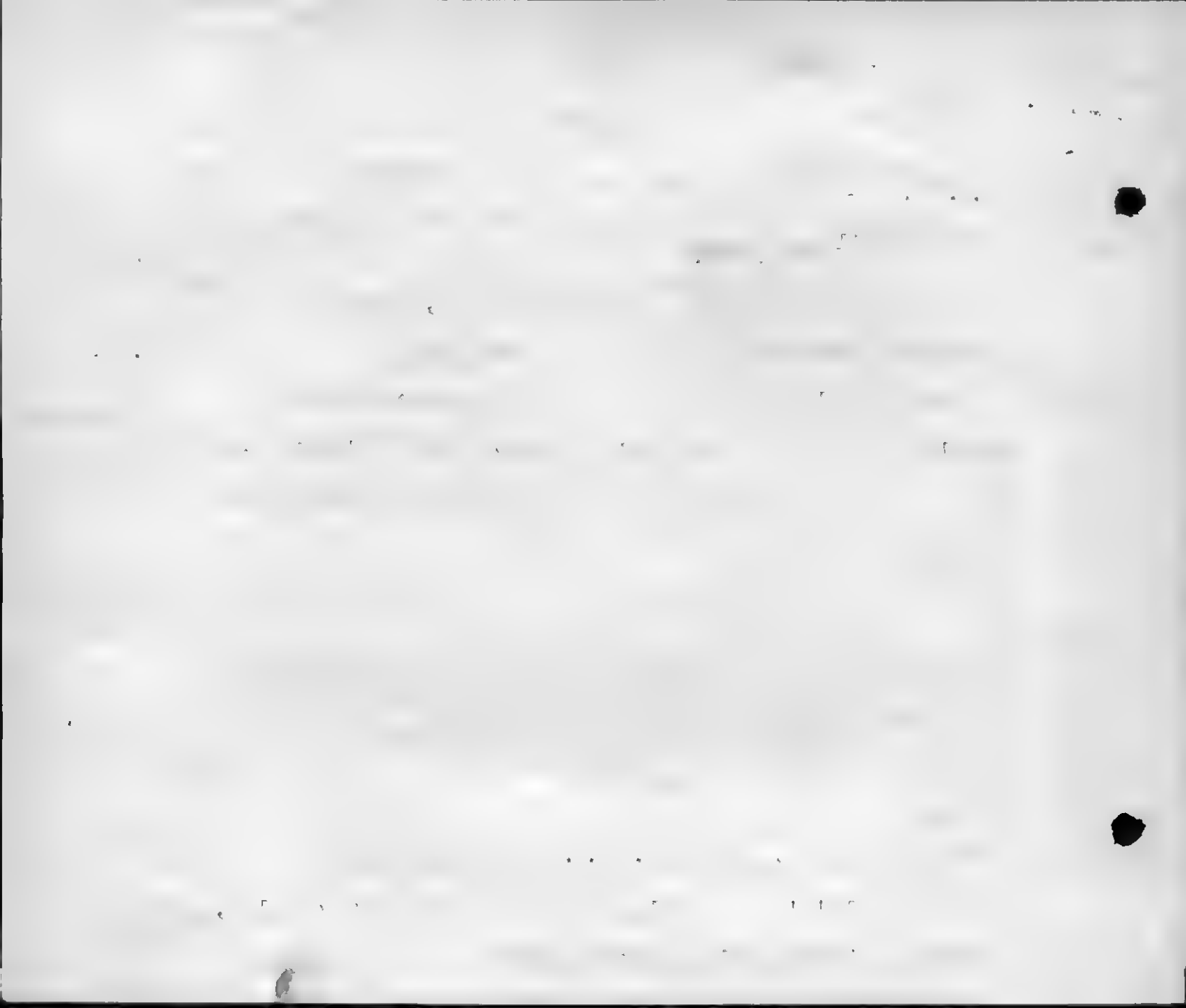
1X
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any part is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
1148 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11463									
1. PLACE OF DEATH a. COUNTY Howard					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE New York b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New Rochelle				
c. LENGTH OF STAY IN 1b					d. STREET ADDRESS 33 Park Avenue				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. Rt. 40 - 1 1/2 miles west of Friendship Airport					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Attilio					4. DATE OF DEATH Month October Day 31 Year 1959				
5. SEX Male					6. COLOR OR RACE White				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH May 11, 1932				
9. AGE (In years, if UNDER 1 YEAR, if UNDER 24 HRS. last birthday) 27 yrs.					10. BIRTHPLACE (State or foreign country) New York				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Landscape Gardener					10b. KIND OF BUSINESS OR INDUSTRY				
11. BIRTHPLACE (State or foreign country) New York					12. CITIZEN OF WHAT COUNTRY? U. S. A.				
13. FATHER'S NAME Michael Gallo					14. MOTHER'S MAIDEN NAME Carmela Chirchelli				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unknown					16. SOCIAL SECURITY NO. unknown				
17. INFORMANT Sisto & Paino Funeral Home New York					Address New Rochelle				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple traumatic injuries and 3rd degree burns DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 810X									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver in auto-tractor trailer collision									
20c. TIME OF INJURY Month, Day, Year 9:45 10/31 1959									
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Road									
20f. (City or town) (County) (State) Ellicott City, Howard, Md.									
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
CHIEF MEDICAL EXAMINER <input type="checkbox"/>									
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>									
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>									
DATE SIGNED 11/2/59									
ACTUAL SIGNATURE William V. Lovitt, Jr., M.D.									
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial									
22b. DATE THEREOF 11/6/59									
22c. NAME OF CEMETERY OR CREMATORY Holy Sepulchre Cem.									
22d. LOCATION (City, town, or country) (State) New Rochelle, New York									
23. FUNERAL DIRECTOR Howard H. Hubbard 4107 Wilkens Avenue									
ADDRESS									
24a. REC'D BY REGISTRAR NOV 4 '59									
24b. REGISTRAR'S SIGNATURE William E. Hanna									



1X
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the information is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

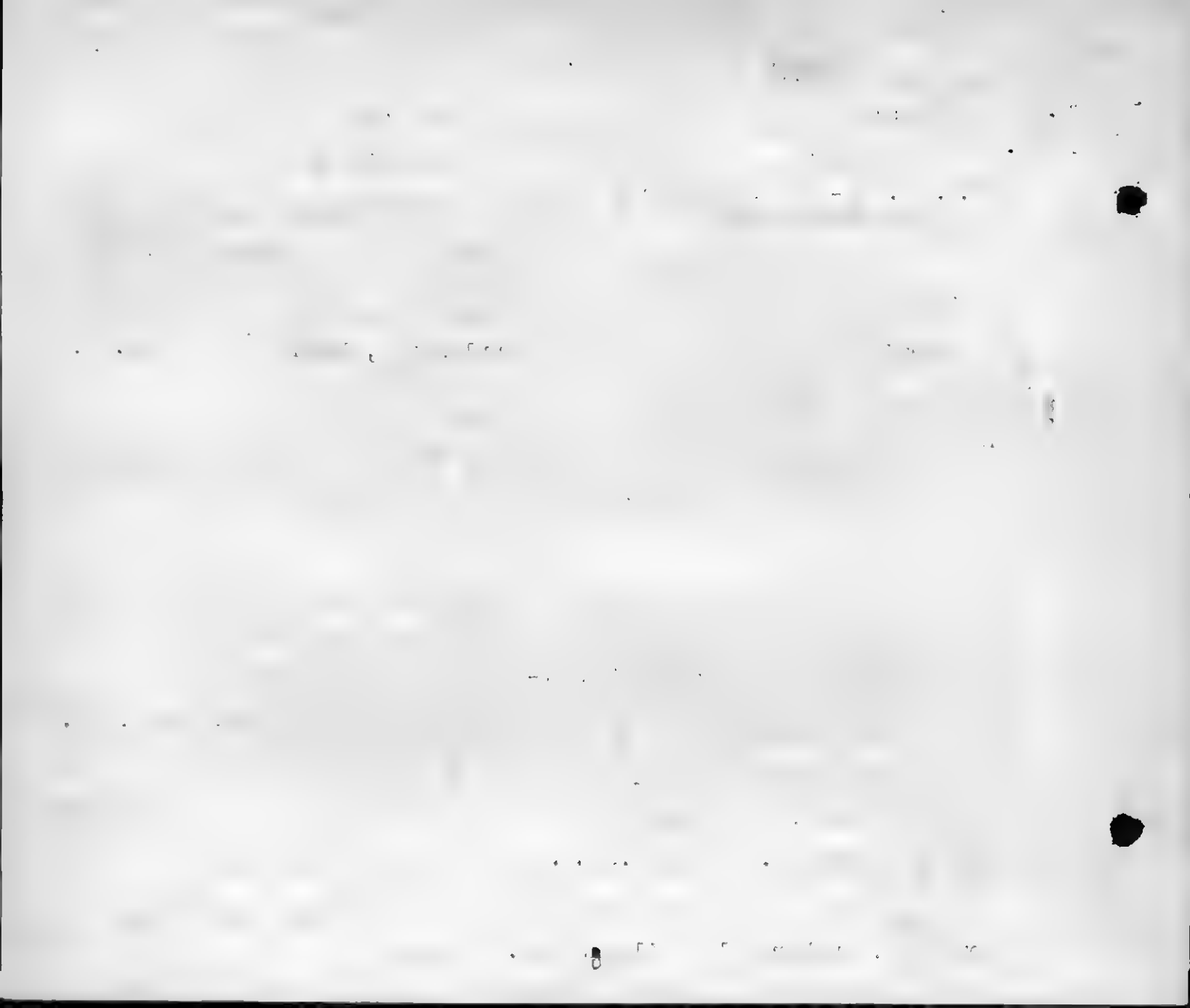
VS. A15ME
5M 7/59

11482
MAYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11464

1. PLACE OF DEATH a. COUNTY Howard		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE New York b. COUNTY New Rochelle	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New Rochelle	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. Rt. 40 - 1 1/2 miles West of Friendship Airport		d. STREET ADDRESS 33 Park Avenue	
3. NAME OF DECEASED (Type or print) PATTI ANN GALLO		4. DATE OF DEATH October 31, 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/12/40
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME WALTER BRUNELLE		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) no		16. SOCIAL SECURITY NO. 215-CC-4602	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple traumatic injuries and 3rd degree burns DUE TO (b) 100X DUE TO (c) 100X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PARTIAL		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in auto-tractor trailer collision	
20c. TIME OF INJURY Month, Day, Year 9:45 10/31 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Road		20f. (City or town) (County) (State) Ellicott City, Howard, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE William V. Lovitt, Jr., M.D.		DATE SIGNED 11/2/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 11/6/59	
22c. NAME OF CEMETERY OR CREMATORY Holy Sepulchre		22d. LOCATION (City, town, or country) (State) New Rochelle	
23. FUNERAL DIRECTOR Howard H. Hubbard 4107 Wilkens Ave.		24a. REC'D BY REGISTRAR DATE NOV 4 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11483

CERTIFICATE OF DEATH

Reg. Dist. No.

11465

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pro George's ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fulton Md				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Simons Rest Home				d. STREET ADDRESS 8202 Adelphi Road			
3. NAME OF DECEASED (Type or print) First Joseph Middle Patrick Last Gowen Sr.				4. DATE OF DEATH Month October Day 29 Year 19 59-			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 10, 1884	9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Thomas Gowen			14. MOTHER'S MAIDEN NAME Bridget Ann Meeham				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Nellie G Gowen Hyattsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 446X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Nephrosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH 5 days 2 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)		(County)	(State)	
21. I certify that I attended the deceased from 7-27- , 19 59 , to 10-29- , 19 59 , that I last saw the deceased alive on 10-26- , 19 59 , and that death occurred at 6:05A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE Charles S. Whitaker M.D. _____ PHYSICIAN'S NAME (Type) Charles S. Whitaker, M.D. Clarksville, Md. 10-29-59							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct 31, 1959	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	22d. LOCATION (City, town, or county) Colmar Manor, Md.		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons			24a. REC'D BY REGISTRAR DATE NOV 2 '59		24b. REGISTRAR'S SIGNATURE Charles S. Whitaker		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 1
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

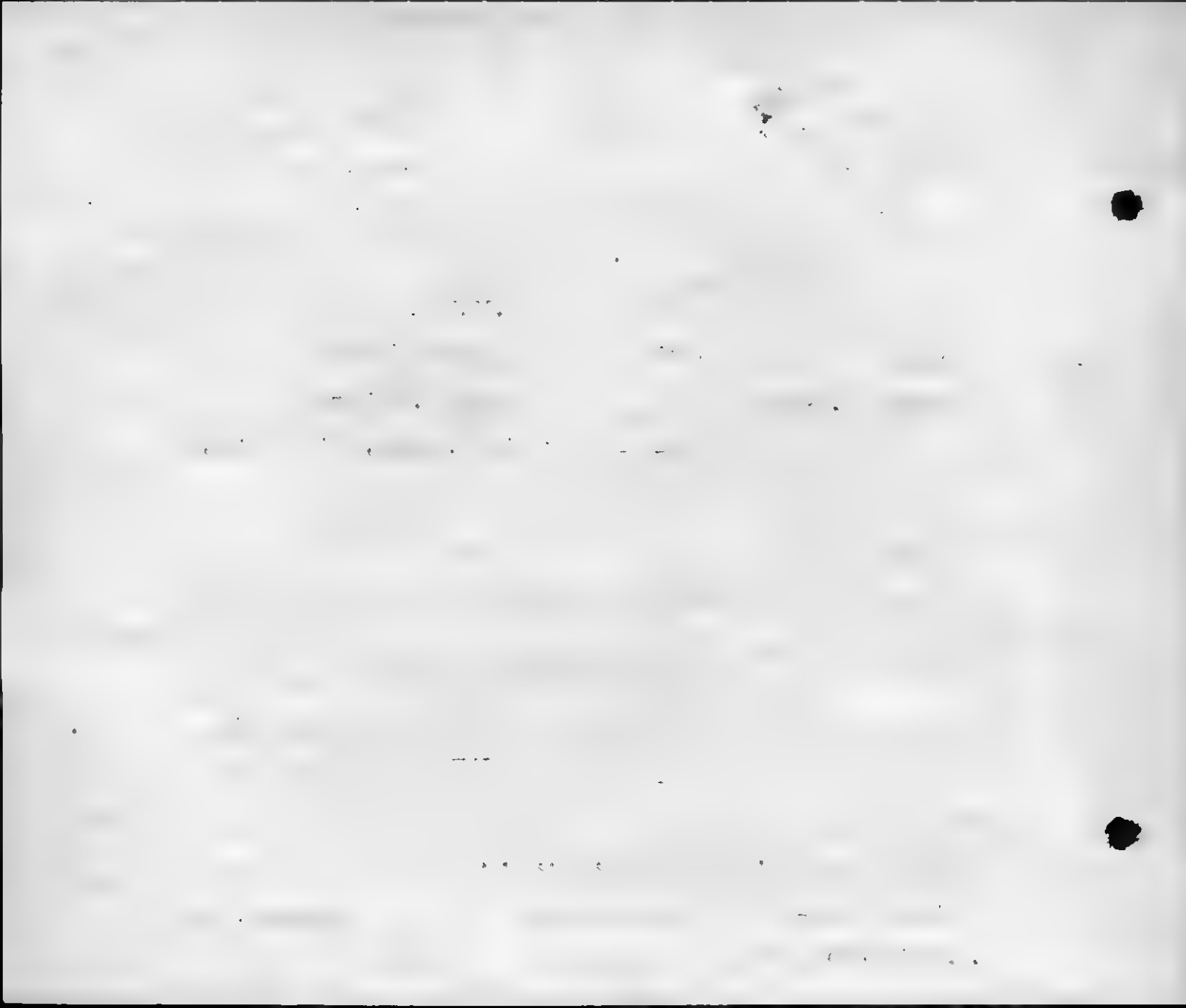
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11466

1. PLACE OF DEATH a. COUNTY HOWARD 11484				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City Rural				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City			
c. LENGTH OF STAY IN 1b				d. STREET ADDRESS Route 4			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 4				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) GEORGE		First Middle Last M. MANNER		4. DATE OF DEATH October 30 1959		Month Day Year	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 13, 1911	
9. AGE (In years last birthday) 47 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		11. BIRTHPLACE (State or foreign country) Ellicott City, Md		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Lawrence J. Manner				14. MOTHER'S MAIDEN NAME Elnora T. Madigan			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 213-16-6938			
17. INFORMANT Pauline C. Manner, Ellicott City, Md				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Traumatic asphyxia							
912.1 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Farm tractor overturned, pinning him under it							
20c. TIME OF INJURY 9:45 a.m.		Month, Day, Year 10/30/59		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Farm	
20f. (City or town) Ellicott City		20g. (County) Md.		20h. (State) Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE W. Bradley King, Jr.				M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) W. Bradley King, Jr., M.D.				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 11-3-59		22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer	
22d. LOCATION (City, town, or country) Baltimore, Md				22e. (State) Md			
23. FUNERAL DIRECTOR F.C. Higinbotham, Ellicott City, Md				24a. REC'D BY REGISTRAR NOV 2 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

VS. A15ME
SM 7/59

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Page 5 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11485

CERTIFICATE OF DEATH

Reg. Dist. No. 11467

1. PLACE OF DEATH a. COUNTY Howard b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City d. STREET ADDRESS Montgomery Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle F. Last REX		4. DATE OF DEATH Month Oct. Day 31 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-1-1910	9. AGE (In years last birthday) yrs. 49	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Service Station Owner		10b. KIND OF BUSINESS OR INDUSTRY Gasoline	11. BIRTHPLACE (State or foreign country) Baltimore, Md		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Frederick Rex			14. MOTHER'S MAIDEN NAME Bertha Huber		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-03-5964	INFORMANT Address Mrs. Mae Schoene, Ellicott City, Md		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 CARDIAC ARREST DUE TO (b) CORONARY THROMBOSIS DUE TO (c) ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH 10 MIN. 30 MIN. 10 YRS.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from 10-31 , 19 59 , to 10-31 , 19 59 that I last saw the deceased alive on 10-31 , 19 59 , and that death occurred at 10:10 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Columbia Road DATE SIGNED ACTUAL SIGNATURE P. V. Thorpe M.D. Ellicott City, Md. PHYSICIAN'S NAME (Type) Peter V. Thorpe M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-3-59	22c. NAME OF CEMETERY OR CREMATORY St. Johns Lutheran		22d. LOCATION (City, town, or county) (State) Pfiffers Corner, Md	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS F.C. Higinbotham, Ellicott City, Md		24a. REC'D BY REGISTRAR DATE NOV 3 '59	24b. REGISTRAR'S SIGNATURE Arthur E. Hump		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11482

Chicago, Illinois

Chicago, Illinois

Chicago, Illinois

Oct. 1, 1934

1934

1934

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1934

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Chicago, Illinois

Chicago, Illinois

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Chicago, Illinois

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11486

CERTIFICATE OF DEATH

Reg. Dist. No. 11468

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Woodbine</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Woodbine 2, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>Old Annapolis Road</u>	
3. NAME OF DECEASED (Type or print) <u>LLOYD L.</u> First Middle Last		4. DATE OF DEATH <u>October 9</u> 19 <u>59</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 28, 1896</u>
9. AGE (In years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labour</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William T. Smith</u>		14. MOTHER'S MAIDEN NAME <u>Maria Coffin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT <u>Myrtle V. Smith - Woodbine 2, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS, Hypertension</u> 241X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Asthma,</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1957</u> <u>to</u> <u>9 Oct 59</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1957</u> , 19 <u>57</u> , to <u>9 Oct</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9 Oct</u> , 19 <u>59</u> , and that death occurred at <u>8:00 A.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Howard E. Hall</u> M.D.		DATE SIGNED <u>9 Oct 59</u>	
PHYSICIAN'S NAME (Type) <u>HOWARD E. HALL</u>		<u>Sylkesville, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-12-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Bushy Park</u>		22d. LOCATION (City, town, or county) (State) <u>Corksville, Howard, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert H. Haight</u>		ADDRESS <u>Corksville, Md.</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hines</u>	
DATE <u>OCT 13 59</u>			

CERTIFICATE OF DEATH

1905

[Faint, mostly illegible handwritten text on a death certificate form. The form includes fields for name, age, sex, date of death, and cause of death. Some legible fragments include:]

Name: [illegible]
Age: [illegible]
Sex: [illegible]
Date of Death: [illegible]
Cause of Death: [illegible]

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